CHAPTER V

BILLING INSTRUCTIONS

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BILLING INSTRUCTIONS

INTRODUCTION

Virginia Medicaid uses the UB-92 CMS-1450 (UB-92) billing form for all claims and adjustments for inpatient and outpatient hospital services. The data elements and design of the form were determined by the National Uniform Billing Committee. However, a State Uniform Billing Committee (SUBC) was established for the purpose of defining State level codes and fields and for implementing the UB-92 claims form throughout Virginia.

The SUBC prepared a training manual to assist providers and payers in proper implementation of the UB-92, as well as to guide those responsible for claims preparation and processing. While the manual was designed to accommodate Virginia's unique needs, it does not contain certain information which Medicaid inpatient and outpatient hospital providers must have in order to properly utilize the UB-92. This chapter **does not** duplicate the material contained in the *State UB-92 Manual* prepared by the SUBC, which all providers must obtain and update. However, this chapter does provide a condensed outline of UB-92 billing requirements and includes supplementary Medicaid information that is critical for purposes of billing the Medicaid Program. It also presents billing information for the DMAS-30 and DMAS-31 forms. Claims for service must be submitted on the appropriate billing invoice using appropriate billing codes.

MEDICAL ASSISTANCE PROGRAM BILLING FORMS

All claims and adjustments for inpatient and outpatient hospital services must be submitted to Virginia Medicaid on the UB-92 CMS-1450 billing form. All previous hospital invoices have been replaced by the UB-92 CMS-1450 form. The DMAS-30 has been revised effective for claims submitted and postmarked after May 31, 2003. The DMAS-31 form remains unchanged.

Submission of Billing Forms

The Medical Assistance Program regulations require prompt submission of all claims. Hospitals are required to correctly submit claims for service within 12 months of the first date of the incurred charges. Payment will not be made for claims submitted more than 12 months after the date of service. When third-party involvement or prolonged eligibility determination occurs, consideration will be given to processing invoices beyond the 12-month-period, provided these circumstances are clearly documented by the provider and attached to the billing invoices.

Submit completed UB-92 CMS-1450 claim forms to:

Virginia Medical Assistance Program
Post Office Box 27443
Richmond, Virginia 23261

Unless otherwise instructed by DMAS staff, **do not mail claims to DMAS administrative offices as this delays processing of the claims**.

Proper postage is the responsibility of the provider. Envelopes with insufficient postage will be returned to the provider. The U.S. Postal Service sends letters with insufficient postage and no return address to the dead letter office.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (888) 829-5373 and choose Option 2 (EDI).
Fax number: (804)-273-6797

First Health's website: http://virginia.fhsc.com
E-mail: edivmap@fhsc.com

Mailing Address

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

Timely Filing

Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which are not submitted within 12 months from the date of the service. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility

requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a **dated** letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of the delayed eligibility. A copy of the dated letter from the local department of social services indicating the delayed eligibility information must be attached to the claim.

- **Denied Claims** - Denied claims that have been submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  Complete the invoice as usual, explaining the reason for the late submission in the "Remarks" section of the invoice, and attach written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

  A legible original invoice form should be submitted. A copy is retained by the provider for record keeping. All invoices must be mailed (proper postage is the responsibility of the provider and will help prevent mishandling); messenger or hand deliveries will not be accepted.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Use of Rubber Stamps for Physician Documentation

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not overcome other requirements that are not for Medicaid billing purposes. For more complete information, see the *Physician Manual* issued by DMAS.

Replenishment of Billing Materials

The hospital provider must purchase the UB-92 CMS-forms. (The Virginia Hospital and HealthCare Association has a group purchasing plan, or the hospital provider can check with the vendor of its choice.)

As a general rule, DMAS will no longer provide a supply of agency forms which can be downloaded from the DMAS website (www.dmas.state.va.us). To view or access the forms used by DMAS, click on the "Search Forms" function on the left-hand side of the DMAS home page and select "provider" to access provider forms. Then you may either search by form name or number. If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at (804) 780-0076.

INQUIRIES CONCERNING BILLING PROCEDURES

Inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to the HELPLINE staff at this address:

Provider Inquiry Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Recipient verification may be obtained by telephoning:

1-800-884-9730	Toll-Free Throughout the United States
804-965-9732	Richmond and Surrounding Counties
804-965-9733	Richmond and Surrounding Counties

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except state holidays.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (888)-829-5373 and choose Option 2 (EDI).

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by using the Web-based Automated Response System. See Chapter 1 for more information.

THIRD PARTY CARRIERS

By law, the Virginia Medical Assistance Program has secondary liability for its beneficiaries to all other third-party carriers. Other sources must be billed before payment is requested from Virginia Medicaid. The Insurance Information Section of the Medicaid eligibility inquiry can provide information on other carriers that should be billed before Medicaid is billed.

Billing for Patients with Medicare Coverage

Medicare Part A Coinsurance

Effective for admission dates on or after January 1, 2000, DMAS will pay Medicare Part A coinsurance for all approved hospital days regardless of the length of stay except for adult psychiatric services. DMAS will limit the amount of reimbursement to the maximum payment allowed by Virginia Medicaid.

Medicare Part B Coinsurance

For all Part B Services, Medicaid payment for Medicare coinsurance will be limited to the difference between Medicaid's maximum fee for a procedure and the Medicare allowance.

For example, if Medicare allows $10 for a procedure, Medicare's payment is $8 and Medicaid's maximum fee for the same procedure is $9, Medicaid's payment for the coinsurance would be $1. The combined payments by Medicare and Medicaid will not exceed Medicare's or Medicaid's allowable charge, whichever is less, for the procedure.

Patients Entitled to Medicare Part B Only

When a Medicaid patient is entitled to Medicare Part B only, the Medicare Part B coverage pays for certain ancillary services which were rendered to the patient while an inpatient. Payment from Medicare Part B must be received before any additional payment is requested from the Virginia Medicaid Program.

HOSPITAL-BASED PHYSICIAN BILLING

Hospital-based physicians must submit separate billings to DMAS for their professional fees (components) utilizing the CMS-1500 (12-90) billing form. Combined billing of the professional fees on the hospital's invoice (UB-92 CMS-1450) is not allowed by DMAS except for authorized transplant claims.

MOTHER/NEWBORN BILLING

The Newborn Eligibility Report (DMAS-213) will assist hospitals in obtaining a Medicaid enrollee number for newborns immediately after birth. The Newborn Eligibility Report (DMAS-213) should be completed by the hospital and sent to the local department of social services (DSS) office to obtain an identification number for billing purposes. The mother will no longer have to contact DSS herself to obtain the Medicaid identification number for the newborn, but she still may choose to do this herself. The Newborn Eligibility Report form is included in the "Exhibits" section at the end of the chapter.

Reimbursement for newborns is included in the mother's reimbursement, but all newborn data must be reported on a claim separate from the mother's (effective for services on or after July 1, 1996 and prior to January 1, 2000). Claims for newborns who go home with the mother must be billed under the newborn's unique identification number using revenue code 0170 or 0171 (no dollars will be paid). For claims for sick newborns who stay beyond the mother's discharge, newborn days that occur before the mother's discharge must be billed with revenue code 0170 (payment will be zero for these days), and days after the mother's discharge must be billed with revenue code 0172 or 0179 (payment will be made).

Claims for newborns born on or after January 1, 2000, are to be billed using any combination of revenue codes, and their claims will be reimbursed based on the DRG payment methodology.

BILLING FOR TRANSPLANT SERVICES

Reimbursement for organ transplants is a global fee that covers procurement costs, all hospital costs from admission to discharge for the transplant procedure, and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, anesthesiologists, etc. The global fee does not include pre- and post-hospitalization for the transplant procedure, pre-transplant evaluation, or organ search. To ensure that reimbursement is calculated correctly, hospitals must include all physicians' fees on the claim. Reimbursement shall be based on the global fee amount or the actual charges, should they be less than the contractual fee. Send the claims for the transplant procedure directly to:

Manager, Payment Processing Unit
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

The letter of authorization from the DMAS Medical Support Unit must accompany the hospital invoice.

DRG-RELATED BILLING CHANGES

Effective with admissions on or after January 1, 2000, DMAS will process and pay claims by All Patient-Diagnosis Related Group (DRG) payment methodology. Proper coding of ICD-9-CM diagnosis and procedure codes, as well as accurate and complete recording of all data elements that affect DRG assignment, is very important to ensuring that the hospital is properly reimbursed. Consistent with the transition to DRGs, the following billing changes were implemented:

- Newborns must be billed under the newborn's unique Medicaid identification number for dates of service on or after July 1, 1996.

- After July 1, 1996, split billing will not be allowed on either the hospital or state fiscal year end. The DRG part of reimbursement will recognize all services on the date of discharge, and the per diem part of reimbursement will accumulate all days to the discharge date for reimbursement and cost settlement purposes.

- Effective with admissions on or after July 1, 1996, whenever a patient is transferred between a medical/surgical unit and a psychiatric unit of the same hospital or the focus of the principal diagnosis is changed from medical/surgical diagnosis to one that is psychiatric, the stay in the medical/surgical unit must be billed as an admission and discharge separate from the treatment stay in the psychiatric unit. The medical surgical stay will be reimbursed under the DRG methodology as one distinct stay (discharge), while the days in the psychiatric unit will be reimbursed under the psychiatric

per diem methodology. In addition, billing for each medical/surgical and psychiatric admission must coincide with the appropriate ICD-9 diagnosis code supporting the admission and the prior authorization type for appropriate reimbursement.

- A transfer case is a patient who is discharged from one hospital and admitted to another within five (5) days with the same or similar diagnosis. If the transferring hospital reports the correct patient discharge status code, the transfer case will be identified in the weekly processing and will be paid correctly. Transfer cases that are not identified through correct reporting of a patient discharge status code on the claim will be identified in the monthly case building process as "implied transfers." When implied transfers are identified, a DRG payment may have already been made to the transferring hospital. This payment will be adjusted and a per diem payment made. These transactions will be reported on the remittance following the monthly cycle that identified the implied transfer. The receiving hospital will receive the DRG payment.

- A readmission occurs when a patient is discharged and returns to the same hospital within five (5) days with the same or similar diagnosis. These cases are considered a single case rather than two. Readmissions will be identified in the monthly processing cycle. Often when this occurs, one or both claims will already have been paid. The payment of the first claim will be adjusted to reflect a payment for the combined case, and an adjustment will be made to the second claim reflecting a zero payment. The corrected processing will recognize all the coding and charges from both claims for purposes of DRG assignment and potential outlier determination. These transactions will be reported on the remittance following the monthly cycle that identified the readmission.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after October 15, 2003, and all local service codes will no longer be accepted for claims with dates of service after October 15, 2003. All claims submitted with dates of service after October 15, 2003 will be denied if local codes are used.

DMAS will accept the National Standard Formats (NSF) for electronic claims submitted on or before October 15, 2003. On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted. Beginning with electronic claims submitted on or after October 16, 2003, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted). National Codes that replace Local Codes will be accepted for claims with dates of service on or after June 20, 2003. National Codes become mandatory for claims with dates of service on or after this date.

The transactions for hospital claims include:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) claims
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

Information on these transactions can be obtained from our fiscal agent's website: http://virginia.fhsc.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

CLAIMCHECK

ClaimCheck is a fully automated auditing system that verifies the clinical accuracy of claims submitted and reimbursed. DMAS uses ClaimCheck as a post-payment review of professional and laboratory claims. As a result of this auditing process, DMAS makes the necessary voids or adjustment of the claim(s).

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

PROVIDER FRAUD

The provider is responsible for complying with applicable state and federal laws and regulations and the requirements set forth in this manual. If electronically submitting claims or using electronic submission, use EDI format Version 5 prior to May 31, 2003. For electronic submissions on or after June 3, 2003, use EDI transactions specifications

published in the ASC X12 Implementation Guides version 4040A1. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence.

Supervisor, Provider Review Unit
Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

RECIPIENT FRAUD

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes that, if known, or both, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

INSTRUCTIONS FOR COMPLETING THE UB-92 CMS-1450 UNIVERSAL CLAIM FORM

The UB-92 CMS-1450 is a universally accepted claim form that is required when billing DMAS for covered services rendered by participating hospitals. (See the "Exhibits" at the end of this chapter for a sample of the form.) The UB-92 has a multi-purpose format so that it can be used for submitting six different types of transactions: original inpatient and outpatient claims, as well as adjusted or voided inpatient or outpatient claims. This is accomplished by coding transaction-specific information in certain locators on the UB-92 form. This form is readily available from printers. The UB-92 CMS-1450 **will not** be provided by DMAS.

The UB-92: General Information

- All dates used on the UB-92 CMS-1450 should be two digits each for the day, the month, and the year (e.g., 010403) with the exception of Locator 14, Patient Birthdate, which requires four digits for the year.

  NOTE; NO SLASHES, DASHES OR SPACES ARE ALLOWED.

- Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

- When coding ICD-9-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

- Do not record cost reduction copayments on this form.

- Continue to use the CMS-1500 invoice to submit outpatient laboratory charges.

- Continue to use the Medicare Title XVIII Deductible and Coinsurance Invoice (DMAS-30) when appropriate.

- The professional fee is not a reportable item on the UB-92 CMS-1450 for general hospital inpatient or outpatient services. The professional component

must be billed utilizing the CMS-1500 (12-90) billing form (except for authorized transplants).

(Continued on Next Page)

UB-92 Invoice Instructions

The following description outlines the process for completing the UB-92 CMS-1450. It includes Medicaid-specific information and should be used to supplement the material included in the *State UB-92 Manual*. Inpatient/outpatient rehabilitation facility providers should consult the Medicaid *Rehabilitation Manual* (issued by DMAS) for billing information, since the UB-92 CMS-1450 billing requirements for those providers vary slightly from those presented below.

Locator		Instructions
1	**Required**	Enter the provider's name, address, and telephone number.
2	Unlabeled Field	
3	**Required** (if applicable)	**PATIENT CONTROL NUMBER** - Medicaid will accept an account number which does not exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 111 Original Inpatient Hospital Invoice 112 Interim Inpatient Hospital Claim Form* 113 Continuing Inpatient Hospital Claim Invoice* 114 Last Inpatient Hospital Claim Invoice* 117 Adjustment Inpatient Hospital Invoice 118 Void Inpatient Hospital Invoice 131 Original Outpatient Invoice 137 Adjustment Outpatient Invoice 138 Void Outpatient Invoice * The proper use of these codes (see the *State UB-92 Manual*) will enable DMAS to reassemble cycle-billed claims to form DRG cases for purposes of DRG payment calculations and cost settlement.
5	Not Required	**FED. TAX No.**
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day.

Locator		Instructions
		For hospital admissions on or after January 1, 2000, the billing cycle for general medical surgical services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Psychiatric services for adults remains limited to the 21 days. Interim claims (bill types 112 or 113) submitted with less than 120 day will be denied. Bill type 111 or 114 submitted with greater than 120 days will be denied.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid-covered days as applicable. This should be the total number of covered accommodation days/units reported in Locator 46.
8	**Required**	**N-CD. (Non-Covered Days)** - Enter the days of care not covered for inpatient only. Non-covered days are not included in covered days. (Not required for outpatient rehabilitation agencies).
9	Not required	C-ID. (Coinsurance Days)
10	Not required	L-RD. (Lifetime Reserve Days)
11	Unlabeled Field	
12	**Required**	**PATIENT NAME** - Enter the patient's name - last, first, and middle initial.
13	**Required**	**PATIENT ADDRESS** - Enter the patient's address.
14	**Required**	**BIRTHDATE** - Enter the month, date, and full year (MMDDCCYY).
15	**Required**	**SEX** - Enter the sex of the patient as recorded on the date of admission, outpatient service, or start of care.
16	Optional	MS (Patient's Marital Status)
17	**Required**	**DATE (Admission Date)** - Enter the date of admission for inpatient care. This date must be the same date for all interim claims related to the same admission. Enter the date of service for outpatient care.
18	**Required**	**HR (Admission Hour)** - Enter the hour during which

Locator		Instructions
		the patient was admitted for inpatient or outpatient care. (Not required for outpatient rehabilitation agencies)
19	**Required**	**TYPE (Type of Admission)** - For inpatient services only, enter the appropriate code indicating the priority of admission. A code "1" (emergency) indicates that a copay does not apply.
20	**Required**	**SRC (Source of Admission)** - Enter the appropriate code for the source of the admission. Code "7" (Emergency Room) indicates copay does not apply.
21	**Required**	**D HR (Discharge Hour)** - Enter the hour the patient was discharged from inpatient care.
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the ending date in Statement Covers Period (Locator 6). (If the patient was a one-day stay, enter code "30" for admissions prior to July 1, 1996 and code "01" for admissions on or after July 1, 1996.) Correct reporting of the patient status code will facilitate quick and accurate determination of DRG reimbursement. In particular, accurate reporting of the values 01, 02, 05, and 30 will be very important in a DRG methodology.
23	**Required (if applicable)**	**MEDICAL RECORD NO.** - Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: This number should not be substituted for the Patient Control Number (Loc. 3 which is assigned by the provider to facilitate retrieval of the individual financial record).
24-30	**Required (if applicable)**	**CONDITION CODES** - Enter the code(s) in numerical sequence (starting with 01) which identify conditions relating to this bill that may affect payer processing. Include the Special Program Indicator codes listed below, if applicable: A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION DANGER TO LIFE A8 INDUCED ABORTION VICTIM RAPE/INCEST

31 Unlabeled Field Locator		Instructions
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing. This is important when billing for days that were exhausted by Medicare.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES** - Enter the code(s) and related dates that identify an event related to the payment of this claim. If code 71 is used, enter the FROM/THROUGH dates given by the patient for any hospital, skilled nursing facility (SNF), or nursing facility stay that ended within 60 days of this hospital admission.
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the nine to 16 digit claim reference number of the paid claim to be adjusted or voided. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). Be sure to use the appropriate type of bill (Locator 4) in combination with the reference number from the incorrect claim. NOTE: A=Primary Payer B=Secondary Payer C=Tertiary Payer Cross-Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	Optional	RESPONSIBLE PARTY NAME AND ADDRESS
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim. One of the following codes **must** be used: 82 No Other Coverage 83 Billed and Paid (enter amount paid by primary carrier)

85 Billed Not Covered/No Payment

Locator		Instructions
		Other codes may be used if applicable.
42	**Required**	**REV. CD. (Revenue Codes)** - Enter the appropriate revenue code(s) for the service provided as follows: **CODE: Four digits, leading zero, left justified, if applicable.** See the Revenue Codes list under "Exhibits" at the end of this chapter for approved DMAS codes.
43	**Required**	**DESCRIPTION** - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the State UB-92 billing manual).
44	**Required (if applicable)**	**HCPCS/RATES** Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered.
45	**Required (if applicable)**	**SERV. DATE** - Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges must include only covered charges. Note: Use code "0001" for TOTAL.
48	Optional	**NON-COVERED CHARGES** - Reflects non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "0001" for TOTAL non-covered charges. (Enter the grand total

for both total charges and non-covered charges on the same line of revenue code "0001.")

Locator		Instructions
49	Unlabeled Field	
50	**A-C. Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C.
51	**A-C Required**	**PROVIDER NO.** - The Medicaid Provider ID #. Enter this number on the appropriate line. A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information - Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits - Certification Indicator)
54	A,B,C,P Required (if applicable)	PRIOR PAYMENTS (Payers and Patients) <u>Long-Term Hospitals</u> - Enter the patient pay amount on "P" line as shown on the DMAS-122 Form furnished by the Local Department of Social Services Office. Note: A=Primary B=Secondary C=Tertiary P= Due from Patient **<u>DO NOT ENTER THE MEDICAID COPAY AMOUNT</u>**
55	A,B,C,P	EST AMOUNT DUE

Locator	Not Required	Instructions
56	Unlabeled Field	
57	Unlabeled Field	
58	**A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer identified on Line A, Locator 50. • Enter the insured's name used by the secondary payer identified on Line B, Locator 50. • Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.
59	**A-C Required**	**P. REL** - Enter the code indicating the relationship of the insured to the patient. Refer to the *State UB-92 Manual* for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT. - SSN - HIC - ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. NOTE: The Medicaid enrollee ID # is 12 digits.
61	**A-C Required (if applicable)**	**GROUP NAME** - Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable)**	**INSURANCE GROUP NO.** - Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.

Locator		Instructions
63	**Required (if applicable)**	**TREATMENT AUTHORIZATION CODES** - Enter the number indicating that the treatment is authorized by the payer. Enter the preauthorization number assigned for the appropriate inpatient and outpatient services.
64	**A-C Required (if applicable)**	**ESC (Employment Status Code)** - Enter the code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME** - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION** - Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD. (Principal Diagnosis Code)** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the ICD-9-CM diagnosis code(s) for diagnoses other than principal (if any). **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.** - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician. **DO NOT USE DECIMALS.**
77	**Required**	**E-CODE** (External Cause of Injury Code)
78	Unlabeled Field	
79	Required	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 - HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if**	**PRINCIPAL PROCEDURE CODE AND DATE** -

Locator		Instructions
	applicable)	Enter the ICD-9-CM procedure code for the major procedure performed during the billing period**. DO NOT USE DECIMALS.** For outpatient claims, a procedure code must appear in this locator when revenue codes 360-369, 420-429, 430-439, and 440-449 (if covered by Medicaid) are used in Locator 42 or the claim will be denied. For inpatient claims, a procedure code or one of the diagnosis codes of V64.1 through V64.3 must appear in this locator (or in Locator 67) when revenue codes 360-369 are used in locator 42 or the claim will be denied. For revenue codes other than those identified above used in Locator 42, the claims will not be denied due to the lack of a procedure code in this locator. Procedure code 8905 will be used by Virginia Medicaid if the locator is left blank. Procedures that are done in the Emergency Room (ER) one day prior to the recipient being admitted for an inpatient hospitalization **from** the ER may be included on the inpatient claim.
81	**A-E Required (if applicable)**	**OTHER PROCEDURE CODES AND DATES** - Enter the ICD-9 CM code(s) identifying all significant procedures other than the principal procedure (and the dates) on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal. **DO NOT USE DECIMALS.**
82	**Required**	**ATTENDING PHYS. ID.** Inpatient: Enter the number assigned by Medicaid for the physician attending the patient. Outpatient: Enter the number assigned by Medicaid for the physician who performs the principal procedure.
83	**A Required (if applicable)**	**OTHER PHYS. ID.** - Enter the provider number assigned by Medicaid for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit. This is required for all MEDALLION patients even though the PCP may be listed in Locator 82. For MEDALLION patients referred to an outpatient clinic, enter the provider ID number assigned by Medicaid for the PCP who authorized the outpatient visit. For Client

Locator		Instructions
		Medical Management (CMM) patients referred to the emergency room by the PCP, enter the provider ID number and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate with a referral. Enter the PCP provider number for all inpatient stays. **THE PCP # MUST BE IN LOCATOR 83-Aa.**
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37). If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. (Required for paper claims only)
86	**Required**	**DATE** - Enter the date on which the bill is submitted to Medicaid. (Required for paper claims only)

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7444

Maintain the Institution copy in the provider files for future reference.

UB-92 (CMS-1450) ADJUSTMENT AND VOID INVOICES

- To adjust a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges.
    - Type of Bill (Locator 4) - Enter code 117 for inpatient hospital services or enter code 137 for outpatient services.
    - Locator 37 - Enter the nine to sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.

- Remarks (Locator 84) - Enter an explanation for the adjustment.

NOTE: Since July 1, 1996, inpatient claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim:

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

- To void a previously paid claim, complete the following data elements on the UB-92 CMS-1450:

  - Type of Bill (Locator 4) - Enter code 118 for inpatient hospital services or enter code 138 for outpatient hospital services.

  - ICN/DCN (Locator 37) - Enter the nine to sixteen digit claim reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.

AMBULATORY SURGERY CENTERS

Billing Instructions

The facility fee for the use of the Ambulatory Surgery Center (ASC) should be billed by using the Current Procedural Terminology (CPT) code that describes the surgery that was performed. Medicaid is using the most recent ASC group listings as defined by Medicare. For the most recent listings, see the Medicare website (www.cms.gov). If you are billing for a procedure that is not included in these listings, your claim will pend for reason 749 and will be manually reviewed for payment. Remember that the fee that is reimbursed to ASCs is for the use of the facility only. The physician performing the surgery will be reimbursed separately by billing the CPT code that describes the surgery performed. The reimbursement rate for physicians is based on the Resource Based Relative Value Scale (RBRVS). The reimbursement rate for facilities is based on fees established by DMAS. Your payment will be determined based on the ASC Group that the procedure falls in. See crosswalk chart below:

Crosswalk from Previous "M" Codes to ASC Group Listings

Old Code	ASC Group	Payment to Facility
M0050	Group 1	$277.44
M0051	Group 2	$371.52
M0052	Group 3	$426.05
M0053	Group 4	$524.83
M0054 (formerly used as an unlisted code for surgeries not found in other ASC Groups)	Group 5	$599.14
No previous code	Group 7	$869.14

*Note: Medicare has established a payment rate for ASC Group 6 but at the present time, there are no procedures that fall under this group; therefore, Medicaid has not established a rate.

Multiple Surgeries Performed in ASCs

If you are billing for two surgeries performed on the same day that fall under the same ASC Group Listing, Medicaid will reimburse you at the rate of 100 percent for one surgery and 50 percent for the second surgery. If you are billing for surgeries that fall under different ASC Group Listings, you will be paid 100 percent for the surgery with the higher payment level and 50 percent for any additional surgeries.

Disposable Supplies

When disposable supplies are used during a procedure (i.e., stapling systems and clips) we will allow reimbursement to the facility provided that with each claim, documentation is attached to support the cost of these supplies. To bill for these supply items, enter CPT code 99070 (unlisted supplies) in Block 24-D of the CMS-1500 claim form and include modifier 22 to request individual consideration.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Instructions for Completing the Title XVIII (Medicare) Deductible and Coinsurance Invoices for Medicare Part A

Virginia Medicaid has arranged with the Medicare intermediary to obtain the Medicare deductible and coinsurance information that DMAS needs to pay the applicable Medicare coinsurance and deductible amounts. This exchange makes payment to providers for the appropriate Medicare Part A coinsurance and deductible amount.

Manual Completion of the Original Title XVIII (Medicare) Deductible and Coinsurance Invoice - DMAS-30

If payment is not received from Medicaid within 60 days of the Medicare payment, the provider should complete and submit the Title XVIII (Medicare) Deductible and Coinsurance Invoice, DMAS-30. Instructions are printed on the reverse side of the form and are included at the end of this section.

Adjustment Coinsurance Invoice, DMAS-31

The adjustment invoice is used to change information on a paid claim. The instructions are on the reverse side of the form.

Void Coinsurance Invoice, DMAS-31

The void invoice is used to void a paid claim. The instructions are on the reverse side of the form.

Instructions for Completing the Title XVIII (Medicare) Deductible and Coinsurance Invoices for Medicare Part B

Virginia Medicaid pays the Medicare Part B premium for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part B carriers serving Virginia and DMAS have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This information will be used by DMAS to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid enrollees who are also covered by Medicare Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part B carrier is one of these, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the enrollee's Medicare number and the provider's

Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to DMAS to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid enrollees with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 invoice form should be completed, and a copy of the EOB attached and forwarded to:

Department of Medical Assistance Services
P. O. Box 27444
Richmond, Virginia 23261-7444

VIRGINIA MEDICAL ASSISTANCE PROGRAM CLAIM FORM EXAMPLES

Sample claim forms are found in "Exhibits" at the end of this chapter.

For general billing reminders, follow the guidelines below.

- Type the entire claim, if possible.
- Submit original claims only.
- Use capital letters.
- Type inside the data fields.
- Print in black.
- Enter complete dollar amount, including cents field.
- Use no symbols.
- Align numbers.
- Enter dates in six-digit format (Example: 04 05 03).
- Do not fold claims.
- Signature of provider/representative is required.

Instructions For the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 – R 6/03

Purpose: To provide a method of billing Virginia Medicaid for Medicare deductible and coinsurance.

NOTE: This form can be used for four different procedures **per** Medicaid recipient. A different form must be used for **each** Medicaid enrollee.

Block 01 **Provider's Medicaid ID Number** – Enter the 9-digit Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears from the enrollee's eligibility verification.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears from the enrollee's eligibility verification.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Recipient's HIB Number (Medicare)** – Enter the enrollee's Medicare number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 – No Other Coverage** – If there is not other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** – Mark the appropriate type of Medicare coverage.

Block 09 **Diagnosis** – Enter the principal ICD-9-CM diagnosis code, omitting the

decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. If there was no procedure code billed to Medicare, leave this block blank. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission.

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the co-insurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice, DMAS-31 (Rev. 6/96)

Purpose To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** – Enter the Virginia Medicaid provider identification number assigned by Virginia Medicaid.

Block 2A **Reference Number** - Enter the reference number/*ICN* taken from the Remittance Voucher for the line of payment needing *an* adjustment. The adjustment cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Block 3 **Clients' Name** - Enter the last name and the first name of the patient as they appear on the enrollee's eligibility card.

Block 4 **Client's Identification Number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 5 **Patient Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance voucher after the claim is processed.

Block 6 **Client HIB Number** (Medicare) - Enter the enrollee's Medicare number.

Block 7 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 - No Other Coverage** –If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.

- **Code 3 - Billed and Paid** - When an enrollee has other

coverage that makes payment which may only satisfy in part the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Mark type of coverage "B".

Block 9 **Diagnosis** - Enter the primary ICD-9-CM diagnosis code, omitting the decimal. Only one code can be processed.

Block 9A **Place of Treatment** - Enter the appropriate national place of service code:

Block 10 **Accident Indicator** - Check the appropriate box which indicates the reason the treatment was rendered:

Accident - Possible third-party recovery
Emergency - Not an accident
Other - If none of the above

Block 11 **Type of Service** - Enter the appropriate *national* code describing the type of service:

Block 11A **Procedure Code** - Enter the 5-digit CPT/HCPCS code which was billed to Medicare. Each procedure must be billed on a separate line. If there is no procedure code billed to Medicare, leave this blank. Use the appropriate national procedure code modifier if applicable

Block 11B **Visits/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" as billed to Medicare.(Block 13)

Block 12 **Date of Admission** –Enter the date of admission (if applicable).

Block 13 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru), e.g., 03-01-03 to 03-31-03.

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOMB).

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments.)

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and Disposition The information may be typed or legibly handwritten. Mail the completed claims to:

Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

Retain a copy for the office files.

EXHIBITS

TABLE OF CONTENTS

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NEWBORN ELIGIBILITY REPORT

HOSPITAL OR DSS USE ONLY

ANSWER EACH QUESTION (Please Print)

Mother's Name _____
Last First M.I.

Mother's SSN ___-___-____ Date of Birth ____
M M D D Y Y

Mother's Address _____

_____

Is mother enrolled in an HMO? _____ Yes _____ No

If yes, enter name of mother's HMO _____

Mother's Medical Assistance Number _____

Full Name of Newborn(s) Last	First	M.I.	Birth Date MM/DD/YY	Sex	DSS Use Only MA Number Assigned

- **Note: Medicaid eligibility for newborns begins on the date of birth, if the child is born to a Medicaid eligible mother.**

Signature of Mother _____ Date _____

Name of Hospital	Hospital Medicaid ID Number	Signature of Person Completing Form
Date		Telephone Number

MAIL FORM IMMEDIATELY TO:
Local Department of Social Services

DSS Use Only
Date Received _____
Date Processed _____

DMAS - 213
Revised 1/96

APPROVED OMB NO. 0938-0279

	2							3 PATIENT CONTROL NO.		4 TYPE OF BILL
	5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11		
12 PATIENT NAME		13 PATIENT ADDRESS								
14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30 31
32 OCCURRENCE CODE DATE	33 OCCURRENCE CODE DATE	34 OCCURRENCE CODE DATE	35 OCCURRENCE CODE DATE	36 OCCURRENCE SPAN CODE FROM THROUGH				37 A B C		
	39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT					

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
57		**DUE FROM PATIENT ▶**				

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE DATE	81 OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	82 ATTENDING PHYS. ID
	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	OTHER PROCEDURE CODE DATE	83 OTHER PHYS. ID
				OTHER PHYS. ID

84 REMARKS	85 PROVIDER REPRESENTATIVE	86 DATE
	X	

UB-92 HCFA-1450 **OCR / Original**

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

REVENUE CODES TABLE

Effective For Admissions On Or After June 20, 2003

Revenue Code	Description	Cost Code	General Acute Care Hosptials		Rehabilitative Hospitals	
			Inpatient	Outpatient	Inpatient	Outpatient
0001	Total Charge		Y	Y	Y	Y
0100	All Inclusive Rate (R&B + Ancillary)	100	Y	Y	Y	N
0101	All Inclusive R & B	100	Y	N	Y	N
0110	R&B-Pvt-General	110	Y	N	Y	N
0111	R&B-Pvt-Med-Surg-Gyn	110	Y	N	Y	N
0112	R&B-Pvt-Obstetric	110	Y	N	N	N
0113	R&B-Pvt-Pediatric	110	Y	N	Y	N
0114	R&B-Pvt- Psychiatric	110	Y	N	N	N
0115	R&B-Pvt-Hospice		N	N	N	N
0116	R&B-Pvt-Detoxification		N	N	N	N
0117	R&B-Pvt-Oncology	110	Y	Y	N	N
0118	R&B-Pvt-Rehabilitation	110	Y	N	Y	N
0119	R&B-Pvt-Other	110	Y	N	Y	N
0120	R&B-Semi-Pvt-2 Bed-General	120	Y	N	Y	N
0121	R&B-2 Bed-Med-Surg-Gyn	120	Y	N	Y	N
0122	R&B-2 Bed-Obstetric	120	Y	N	N	N
0123	R&B-2 Bed-Pediatric	120	Y	N	Y	N
0124	R&B-2 Bed-Psychiatric	120	Y	N	N	N
0125	R&B-2 Bed-Hospice		N	N	N	N
0126	R&B-2 Bed-Detoxification		N	N	N	N
0127	R&B-2 Bed-Oncology	120	Y	N	N	N
0128	R & B-2 Bed-Rehabilitation	120	Y	N	Y	N
0129	R&B-2 Bed-Other	120	Y	N	Y	N
0130	R&B-3-4 Bed-General	130	Y	N	Y	N
0131	R&B-3-4 Bed-Med-Surg-Gyn	130	Y	N	Y	N
0132	R&B-3-4 Bed-Obstetric	130	Y	N	N	N
0133	R&B-3-4 Bed-Pediatric	130	Y	N	Y	N
0134	R&B-3-4 Bed-Psychiatric	130	Y	N	N	N
0135	R&B-3-4 Bed-Hospice		N	N	N	N
0136	R&B-3-4 Bed-Detoxification		N	N	N	N
0137	R&B-3-4 Bed-Oncology	130	Y	N	N	N
0138	R & B-3-4 Bed-Rehabilitation	130	Y	N	Y	N
0139	R&B-3-4 Bed-Other	130	Y	N	Y	N
0140	R&B-Pvt-Deluxe-General		N	N	N	N
0141	R&B-Pvt Deluxe-Med-Surg-Gyn		N	N	N	N
0142	R&B-Pvt-Deluxe-Obstetric		N	N	N	N

0143	R&B-Pvt-Deluxe-Pediatric		N	N	N	N
0144	R&B-Pvt-Deluxe-Psychiatric		N	N	N	N
0145	R&B-Pvt-Deluxe-Hospice		N	N	N	N
0146	R&B-Pvt-Deluxe-Detoxification		N	N	N	N
0147	R&B-Pvt-Deluxe-Oncology		N	N	N	N
0148	R & B-Pvt Deluxe-Rehabilitation		N	N	N	N
0149	R&B-Pvt-Deluxe-Other		N	N	N	N
0150	R&B-Ward-General	150	Y	N	Y	N
0151	R&B-Ward-Med-Surg-Gyn	150	Y	N	Y	N
0152	R&B-Ward-Obstetric	150	Y	N	N	N
0153	R&B-Ward-Pediatric	150	Y	N	Y	N
0154	R&B-Ward-Psychiatric	150	Y	N	N	N
0155	R&B-Ward-Hospice		N	N	N	N
0156	R&B-Ward-Detoxification		N	N	N	N
0157	R&B-Ward-Oncology	150	Y	N	N	N
0158	R & B-Ward-Rehabilitation	150	Y	N	Y	N
0159	R&B-Ward-Other	150	Y	N	Y	N
0160	Other R&B-General	160	Y	N	Y	N
0164	Other R&B-Sterile Environment	160	Y	N	Y	N
0167	Other R&B-Self Care	160	Y	N	Y	N
0169	Other R&B-Other	160	Y	N	Y	N
0170	Nursery-General	170	Y	N	N	N
0171	Nursery-(Level I) Normal Newborn	171	Y	N	N	N
0172	Nursery-(Level II) Premature Newborn	172	Y	N	N	N
0173	Nursery-Level III-Sick Neonate	173	Y	N	N	N
0174	Nursery Level IV-Intensive Neonate	174	Y	N	N	N
0179	Nursery-Other	179	Y	N	Y	N
0180	Leave Of Absence (LOA) Gen	180	N	N	N	N
0181	LOA-Reserved		N	N	N	N
0182	LOA-Patient Convenience	182	N	N	N	N
0183	LOA-Therapeutic	183	N	N	N	N
0184	LOA-ICF-MR, Any Reason	184	N	N	N	N
0185	LOA-Nursing Home for Hospital	185	N	N	N	N
0189	LOA-Other	189	N	N	N	N
0190	Subacute Care-General		N	N	N	N
0191	Subacute Care-Level I-Skilled Care		N	N	N	N
0192	Subacute -Level II-Comprehensive C		N	N	N	N
0193	Subacute-Level-III-Complex Care		N	N	N	N
0194	Subacute-Level-IV-Intensive Care		N	N	N	N
0199	Subacute Care-Other		N	N	N	N
0200	Intensive Care (ICU)-General	200	Y	N	N	N
0201	ICU-Surgical	200	Y	N	N	N
0202	ICU-Medical	200	Y	N	N	N
0203	ICU-Pediatric	200	Y	N	N	N
0204	ICU-Psychiatric	200	Y	N	N	N
0206	ICU-Intermediate	200	Y	N	N	N
0207	ICU-Burn Care	207	Y	N	N	N
0208	ICU-Trauma	200	Y	N	N	N
0209	ICU-Other	200	Y	N	N	N
0210	Coronary Care (CCU)-General	210	Y	N	N	N
0211	CCU-Myocardial Infarction	210	Y	N	N	N
0212	CCU-Pulmonary	210	Y	N	N	N

0213	CCU-Heart Transplant	210	Y	N	N	N
0214	CCU-Intermediate	210	Y	N	N	N
0219	CCU-Other	210	Y	N	N	N
0220	Special Charges-General		N	N	N	N
0221	Special Charges-Admit Charge		N	N	N	N
0222	Special Charges-Technical Support		N	N	N	N
0223	Special Charges-U.R. Service Charge		N	N	N	N
0224	Special Charges-Late D/C, Med Nec	224	Y	N	Y	N
0229	Special Charges-Other		N	N	N	N
0230	Incremental Nsg. Care Rate-Gen	230	Y	N	Y	N
0231	Increm Nsg. Care Rate-Nursery	230	Y	N	N	N
0232	Increm Nsg. Care Rate-Obstetric	230	Y	N	N	N
0233	Increm Nsg. Care Rate-ICU	230	Y	N	N	N
0234	Increm Nsg. Care Rate-CCU	230	Y	N	N	N
0235	Increm Nsg. Care Rate-Hospice		N	N	N	N
0239	Increm Nsg. Care Rate-Other	230	Y	N	N	N
0240	All Inclusive Ancillary-General	240	Y	Y	Y	Y
0241	All Inclusive Ancillary-Basic	240	Y	Y	Y	Y
0242	All Inclusive Ancillary-Comprehensive	240	Y	Y	Y	Y
0243	All Inclusive Ancillary-Specialty	240	Y	Y	Y	Y
0249	All Inclusive Ancillary-Other	240	Y	Y	Y	Y
0250	Pharmacy (Drugs)-General	250	Y	Y	Y	Y
0251	Drugs-Generic	250	Y	Y	Y	Y
0252	Drugs-Non-Generic	250	Y	Y	Y	Y
0253	Drugs-Take Home	250	Y	Y	Y	Y
0254	Drugs-Incident to Other Diagnostic S	250	Y	Y	Y	Y
0255	Drugs-Incidental to Radiology	250	Y	Y	Y	Y
0256	Drugs-Experimental		N	N	N	N
0257	Drugs-Non-Prescription	250	Y	Y	Y	Y
0258	Drugs-I.V. Solutions	250	Y	Y	Y	Y
0259	Drugs-Other	250	Y	Y	Y	Y
0260	I.V. Therapy-General	260	Y	Y	Y	Y
0261	I.V. Therapy-Infusion Pump	260	Y	Y	Y	Y
0262	I.V. Therapy-Pharmacy Services	260	Y	Y	Y	Y
0263	I.V. Therapy-Drug-Supply Delivery	260	Y	Y	Y	Y
0264	I.V. Therapy-Supplies	260	Y	Y	Y	Y
0269	I.V. Therapy-Other	260	Y	Y	Y	Y
0270	Med-Surg. Supplies-General	270	Y	Y	Y	Y
0271	Med-Surg. Supplies-Non-Sterile	270	Y	Y	Y	Y
0272	Med-Surg. Supplies-Sterile	270	Y	Y	Y	Y
0273	Med-Surg. Supplies-Take Home	270	Y	Y	Y	Y
0274	Med-Surg. Suppl-Prosthetic-Orthotic	270	Y	Y	Y	Y
0275	Med-Surg. Supplies-Pacemaker	270	Y	Y	N	N
0276	Med-Surg. Supplies-Intraocular Lens	270	Y	Y	N	N
0277	Med-Surg. Supplies-O2-Take Home	270	N	N	N	N
0278	Med-Surg. Supplies-Implants	270	Y	Y	Y	Y
0279	Med-Surg. Supplies-Other	270	Y	Y	Y	Y
0280	Oncology-General	280	Y	Y	Y	Y
0289	Oncology-Other	280	Y	Y	Y	Y
0290	Durable Medical Equip.-General	290	Y	Y	Y	Y
0291	Medical Equip-Rental	290	Y	Y	Y	Y
0292	Medical Equip-Purchase of New DME	290	Y	Y	Y	Y

0293	Medical Equip-Purchase 0f Used DME	290	Y	Y	Y	Y
0294	Med- Equip-Supplies/Drugs for DME Effectiveness (HH Agency Only)		N	N	N	N
0299	Medical Equip-Other	290	Y	Y	Y	Y
0300	Laboratory (Lab)-General	300	Y	N	Y	N
0301	Lab-Chemistry	300	Y	N	Y	N
0302	Lab-Immunology	300	Y	N	Y	N
0303	Lab-Renal Patient (Home)		N	N	N	N
0304	Lab-Non-Routine-Dialysis	300	Y	N	Y	N
0305	Lab-Hematology	300	Y	N	Y	N
0306	Lab-Bacteriology-Microbiology	300	Y	N	Y	N
0307	Lab-Urology	300	Y	N	Y	N
0309	Lab-Other	300	Y	N	Y	N
0310	Pathology Lab (Path Lab)-General	310	Y	N	Y	N
0311	Path Lab-Cytology	310	Y	N	Y	N
0312	Path Lab-Histology	310	Y	N	Y	N
0314	Path Lab-Biopsy	310	Y	N	Y	N
0319	Path Lab-Other	310	Y	N	Y	N
0320	Dx X-Ray-General	320	Y	Y	Y	Y
0321	Dx X-Ray-Angiocardiography	320	Y	Y	Y	N
0322	Dx X-Ray-Arthrography	320	Y	Y	Y	N
0323	Dx X-Ray-Arteriography	320	Y	Y	Y	N
0324	Dx X-Ray-Chest	320	Y	Y	Y	Y
0329	Dx X-Ray-Other	320	Y	Y	Y	Y
0330	Therapeutic X-Ray (Rx X-Ray)-Gen	330	Y	Y	Y	Y
0331	Rx X-Ray-Chemotherapy-Injected	330	Y	Y	Y	Y
0332	Rx X-Ray-Chemotherapy-Oral	330	Y	Y	Y	Y
0333	Rx X-Ray-Radiation Therapy	330	Y	Y	Y	Y
0335	Rx X-Ray-Chemotherapy-I.V.	330	Y	Y	Y	Y
0339	Rx X-Ray-Other	330	Y	Y	Y	Y
0340	Nuclear Medicine (Nuc Med)-General	340	Y	Y	Y	Y
0341	Nuclear Medicine-Diagnostic	340	Y	Y	Y	Y
0342	Nuclear Medicine-Therapeutic	340	Y	Y	Y	Y
0349	Nuclear Medicine-Other	340	Y	Y	Y	Y
0350	CT Scan-General	350	Y	Y	Y	Y
0351	CT Scan-Head	350	Y	Y	Y	Y
0352	CT Scan-Body	350	Y	Y	Y	Y
0359	CT Scan-Other	350	Y	Y	Y	Y
0360	Operating Room (OR) Services	360	Y	Y	Y	Y
0361	OR Services-Minor Surgery	360	Y	Y	Y	Y
0362	OR Serv-Organ Trans-other than Kidn	360	Y	N	N	N
0367	OR Serv-Kidney Transplant	360	Y	Y	N	N
0369	OR Services-Other	360	Y	Y	Y	Y
0370	Anesthesia-General	370	Y	Y	Y	Y
0371	Anesthesia-Incident to Radiology	370	Y	Y	Y	Y
0372	Anesthesia-Incident to Other Diag	370	Y	Y	Y	Y
0374	Anesthesia-Acupuncture		N	N	N	N
0379	Anesthesia-Other	370	Y	Y	Y	Y
0380	Blood-General	380	Y	Y	Y	Y
0381	Blood-Packed Red Cells	380	Y	Y	Y	Y
0382	Blood-Whole	380	Y	Y	Y	Y
0383	Blood-Plasma	380	Y	Y	Y	Y

0384	Blood-Platelets	380	Y	Y	Y	Y
0385	Blood-Leucocytes	380	Y	Y	Y	Y
0386	Blood-Other Components	380	Y	Y	Y	Y
0387	Blood-Other Derivatives (Cryopricipit)	380	Y	Y	Y	Y
0389	Blood-Other	380	Y	Y	Y	Y
0390	Blood Storage-Processing-Gen	390	Y	Y	Y	Y
0391	Blood Storage-Administration	390	Y	Y	Y	Y
0399	Blood Storage-Other	390	Y	Y	Y	Y
0400	Imaging Services-General	400	Y	Y	Y	Y
0401	Imaging Serv-Diag.-Mammography	400	Y	Y	Y	Y
0402	Imaging Serv-Ultrasound	400	Y	Y	Y	Y
0403	Imag Serv-Screening Mammogram	400	Y	Y	Y	Y
0404	Imag Serv-Positron Emission Tom	400	Y	Y	Y	Y
0409	Imaging Services-Other	400	Y	Y	Y	Y
0410	Respiratory Services-General	410	Y	Y	Y	Y
0412	Respir Serv-Inhalation	410	Y	Y	Y	Y
0413	Respir Serv-Hyperbaric O2	410	Y	Y	Y	Y
0419	Respir Serv-Other	410	Y	Y	Y	Y
0420	Physical Therapy (P.T.)-General	420	Y	Y	Y	Y
0421	P.T.-Visit Charge	420	Y	Y	Y	Y
0422	P.T.-Hourly Charge	420	Y	Y	Y	Y
0423	P.T.-Group Rate	420	Y	Y	Y	Y
0424	P.T.-Evaluation or Re-evaluation	420	Y	Y	Y	Y
0429	P.T.-Other	420	Y	Y	Y	Y
0430	Occupational Therapy (O.T.)-General	430	Y	Y	Y	Y
0431	O.T.-Visit Charge	430	Y	Y	Y	Y
0432	O.T.-Hourly Charge	430	Y	Y	Y	Y
0433	O.T.-Group Rate	430	Y	Y	Y	Y
0434	O.T.-Evaluation or Re-evaluation	430	Y	Y	Y	Y
0439	O.T.-Other	430	Y	Y	Y	Y
0440	Speech–Language Pathology-General	440	Y	Y	Y	Y
0441	Speech Path-Visit Charge	440	Y	Y	Y	Y
0442	Speech Path-Hourly Charge	440	Y	Y	Y	Y
0443	Speech Path-Group Rate	440	Y	Y	Y	Y
0444	Speech Path-Evaluation or Re-evaluation	440	Y	Y	Y	Y
0449	Speech–Language Path-Other	440	Y	Y	Y	Y
0450	Emergency Room-General	450	Y	Y	N	N
0451	EMTALA-Emerg Med-Screen ServIce	450	Y	Y	N	N
0452	ER Beyond EMTALA Screening	450	Y	Y	N	N
0456	Urgent Care	450	N	Y	N	N
0459	Emergency Room-Other	450	Y	Y	N	N
0460	Pulmonary Function-General	460	Y	Y	Y	Y
0469	Pulmonary Function-Other	460	Y	Y	Y	Y
0470	Audiology-General	470	Y	Y	Y	Y
0471	Audiology-Diagnostic	470	Y	Y	Y	Y
0472	Audiology-Treatment	470	Y	Y	Y	Y
0479	Augiology-Other	470	Y	Y	Y	Y
0480	Cardiology-General	480	Y	Y	Y	Y
0481	Cardiology-Cardiac Cath Lab	480	Y	Y	N	N
0482	Cardiology-Stress Test	480	Y	Y	N	N
0483	Cardiology-Echocardiology	480	Y	Y	N	N
0489	Cardiology-Other	480	Y	Y	Y	Y

0490	Ambulatory Surgical Care-General	490	N	Y	N	N
0499	Ambulatory Surgical Care-Other	490	N	Y	N	N
0500	Outpatient Services-General	500	N	Y	N	Y
0509	Outpatient Services-Other	500	N	Y	N	Y
0510	Clinic-General	510	N	Y	N	N
0511	Clinic-Chronic Pain Center	510	N	Y	N	N
0512	Clinic-Dental Clinic	510	N	Y	N	N
0513	Clinic-Psychiatric	510	N	Y	N	N
0514	Clinic-OB-GYN	510	N	Y	N	N
0515	Clinic-Pediatric	510	N	Y	N	N
0516	Clinic-Urgent Care	510	N	Y	N	N
0517	Clinic-Family Practice	510	N	Y	N	N
0519	Clinic-Other	510	Y	Y	N	N
0520	Free-Standing Clinic-General		N	N	N	N
0521	Free-Stand Clinic-Rural Health Clinic		N	N	N	N
0522	Free-Stand Clinic-Rural Home Health		N	N	N	N
0523	Free-Stand Clinic-Family Practice		N	N	N	N
0526	Free-Stand Clinic-Urgent Care		N	N	N	N
0529	Free-Standing Clinic-Other		N	N	N	N
0530	Osteopathic Services-General	530	Y	Y	Y	Y
0531	Osteopathic Services-Therapy	530	Y	Y	Y	Y
0539	Osteopathic Services-Other	530	Y	Y	Y	Y
0540	Ambulance-General		N	N	N	N
0541	Ambulance-Supplies		N	N	N	N
0542	Ambulance-Med Transport		N	N	N	N
0543	Ambulance-Heart Mobile		N	N	N	N
0544	Ambulance-Oxygen		N	N	N	N
0545	Ambulance-Air Ambulance		N	N	N	N
0546	Ambulance-Neonate		N	N	N	N
0547	Ambulance-Pharmacy		N	N	N	N
0548	Amb-Telephone Transmission EKG		N	N	N	N
0549	Ambulance-Other		N	N	N	N
0550	Skilled Nursing-General		N	N	N	N
0551	Skilled Nursing-Visit Charge		N	N	N	N
0552	Skilled Nursing-Hourly Charge		N	N	N	N
0559	Skilled Nursing-Other		N	N	N	N
0560	Medical Social Serv-General		N	N	N	N
0561	Medical Social Serv-Visit Charge		N	N	N	N
0562	Medical Social Serv-Hourly Charge		N	N	N	N
0569	Medical Social Serv-Other		N	N	N	N
0570	Home Health Aide-General		N	N	N	N
0571	Home Health Aide-Visit Charge		N	N	N	N
0572	Home Health Aide-Hourly Charge		N	N	N	N
0579	Home Health Aide-Other		N	N	N	N
0580	Other Visit-General		N	N	N	N
0581	Other Visit-Visit Charge		N	N	N	N
0582	Other Visit-Hourly Charge		N	N	N	N
0589	Other Visit-Other		N	N	N	N
0590	Home Health-Units of Serv-General		N	N	N	N
0599	Home Health-Units of Service-Other		N	N	N	N
0600	Oxygen (O2) (HH)-General		N	N	N	N
0601	O2 (HH)-State-Equip-Supply-Cont		N	N	N	N

0602	O2 (HH)-State-Equip-Supply-<1 lpm		N	N	N	N
0603	O2 (HH)-State-Equip-Suppy->4 lpm		N	N	N	N
0604	Oxygen (HH)-Portable-Add-on		N	N	N	N
0609	Oxygen, Home Health-Other		N	N	N	N
0610	Magnetic Resonance Technology	610	Y	Y	Y	Y
0611	MRI-Brain (Including Brainstem)	610	Y	Y	Y	Y
0612	MRI-Spinal Cord (Including Spine)	610	Y	Y	Y	Y
0613	Reserved		N	N	N	N
0614	MRI-Other	610	Y	Y	Y	Y
0615	MRA-Head and Neck	610	Y	Y	Y	Y
0616	MRA-Lower Extremities	610	Y	Y	Y	Y
0617	Reserved		N	N	N	N
0618	MRA-Other	610	Y	Y	Y	Y
0619	MRT-Other	610	Y	Y	Y	Y
0621	Med-Sur-Sup-Incident Radiology	620	Y	Y	Y	Y
0622	Med-Sur-Sup-Incident-Other Diagnostic	620	Y	Y	Y	Y
0623	Med-Sur-Sup-Surgical Dressings	620	Y	Y	Y	Y
0624	Med-Sur-Sup-FDA Invest Device		N	N	N	N
0630	Pharmacy Extension-Reserved		N	N	N	N
0631	Pharmacy-Single Source Drug	630	Y	Y	Y	Y
0632	Pharmacy-Multiple Source Drug	630	Y	Y	Y	Y
0633	Pharmacy-Restrictive Prescription	630	Y	Y	Y	Y
0634	Pharmacy-EPO-less than 10,000 Units	630	Y	Y	Y	Y
0635	Pharmacy-EPO-10,000 Units or more	630	Y	Y	Y	Y
0636	Pharmacy-Requiring Detailed Coding	630	Y	Y	Y	Y
0637	Pharmacy-Self-administrable	630	Y	Y	Y	Y
0640	Home (H) I.V.Therapy-General		N	N	N	N
0641	H-IV Therapy-Cent. Line-non-rout		N	N	N	N
0642	H-IV Therapy-Site Care-Cent line		N	N	N	N
0643	H- IV Therapy-IV Start-Chg-Peri li		N	N	N	N
0644	H-IV Therapy-Periph Line-non-rou		N	N	N	N
0645	H-IV Therapy-Train-Pat/CareGiv-CL		N	N	N	N
0646	H-IV Therapy-Train-Disabled Pt.-CL		N	N	N	N
0647	H-IV Therapy-Train-Pat/CareGiv-PL		N	N	N	N
0648	H-IV Therapy-Train-Disabled Pt.-PL		N	N	N	N
0649	H-IV Therapy-Other		N	N	N	N
0650	Hospice Services-General		N	N	N	N
0651	Hospice Serv-Routine-Home Care		N	N	N	N
0652	Hospice Serv-Continuous Home Care		N	N	N	N
0653	Hospice Services-Reserved		N	N	N	N
0654	Hospice Services-Reserved		N	N	N	N
0655	Hospice Serv-Inpatient Respite Care		N	N	N	N
0656	Hospice Serv-General Inpatient Care		N	N	N	N
0657	Hospice Serv-Physician Services		N	N	N	N
0659	Hospice Serv-Other Hospice		N	N	N	N
0660	Respite Care (HHA only)-General		N	N	N	N
0661	Respite Care-Hourly Chg-Skill Nsg		N	N	N	N
0662	Respite Care-Hourly Chg-HH Aide		N	N	N	N
0663	Respite Care-Daily Charge		Y	N	N	N
0669	Respite Care-Other		N	N	N	N
0670	Outpt Special Resid Chg-General		N	N	N	N
0671	Outpt Special Resid-Hosp Based		N	N	N	N

0672	Outpt Special Resid-Contracted		N	N	N	N
0679	Outpt Special Resid Chg-Other		N	N	N	N
0680	Trauma Response Not Used		N	N	N	N
0681	Trauma Response - Level I		N	N	N	N
0682	Trauma Response - Level II		N	N	N	N
0683	Trauma Response - Level III		N	N	N	N
0684	Trauma Response - Level IV		N	N	N	N
0689	Trauma Response - Other		N	N	N	N
069X	Not Assigned		N	N	N	N
0700	Cast Room-General	700	Y	Y	Y	Y
0709	Cast Room-Other	700	Y	Y	Y	Y
0710	Recovery Room-General	710	Y	Y	Y	Y
0719	Recovery Room-Other	710	Y	Y	Y	Y
0720	Labor Room-Delivery-General	720	Y	Y	N	N
0721	Labor-Delivery-Labor	720	Y	Y	N	N
0722	Labor Delivery-Delivery	720	Y	Y	N	N
0723	Labor Delivery-Circumcision	720	Y	Y	N	N
0724	Labor Delivery-Birthing Center	720	Y	Y	N	N
0729	Labor Delivery-Other	720	Y	Y	N	N
0730	EKG-ECG-General	730	Y	Y	Y	Y
0731	EKG-ECG-Holter Monitor	730	Y	Y	Y	Y
0732	EKG-ECG-Telemetry	730	Y	Y	Y	Y
0739	EKG-ECG-Other	730	Y	Y	Y	Y
0740	EEG-General	740	Y	Y	Y	Y
0749	EEG-Other	740	Y	Y	Y	Y
0750	Gastro-Intestinal Services-General	750	Y	Y	Y	Y
0759	Gastro-Intestinal Services-Other	750	Y	Y	Y	Y
0760	Treatment-Observation Room-General	760	Y	Y	Y	Y
0761	Treatment Room	760	Y	Y	Y	Y
0762	Observation Room	760	Y	Y	Y	Y
0769	Treatment Room-Observation-Other	760	Y	Y	Y	Y
0770	Preventive Care Services-General		N	N	N	N
0771	Prevent Care Serv-Vaccine Admin	771	Y	Y	Y	Y
0779	Preventive Care Services-Other		N	N	N	N
0780	Telemedicine-General	780	Y	Y	N	N
0789	Telemedicine-Other		Y	Y	N	N
0790	Lithotrispy-General	790	Y	Y	Y	Y
0799	Lithotripsy-Other	790	Y	Y	Y	Y
0800	Inpat-Renal Dialysis-General	800	Y	N	Y	N
0801	Inpatient Dialysis-Hemodialysis	800	Y	N	Y	N
0802	Inpatient Dialy-Peritoneal-Non-CAPDs	800	Y	N	Y	N
0803	Inpatient Dialysis-CAPD	800	Y	N	Y	N
0804	Inpatient Dialysis-CCPD	800	Y	N	Y	N
0809	Inpatient Dialysis-Other	800	Y	N	Y	N
0810	Organ Acquisition-General	810	Y	N	N	N
0811	Organ Acquisition-Living Donor	810	Y	N	N	N
0812	Organ Acquisition-Cadaver Donor	810	Y	N	N	N
0813	Organ Acquisition-Unknown Donor	810	Y	N	N	N
0814	Unsuccessful Organ Search-	810	Y	Y	N	N
0819	Organ Acquis-Other Donor	810	Y	N	N	N
0820	Hemodialysis Outpt or Home-General	820	N	Y	N	N
0821	Hemodia-Opt or Home-Composite rate	820	N	Y	N	N

0822	Hemodia-Opt or Home-Supplies	820	N	Y	N	N
0823	Hemodia-Opt or Home-Equipment	820	N	Y	N	N
0824	Hemodia-Opt or Home-Maint-100%	820	N	Y	N	N
0825	Hemodia-Opt or Home-Supp Servic	820	N	Y	N	N
0829	Hemodia-Opt or Home-Other	820	N	Y	N	N
0830	Peritoneal Opt or Home-General	830	N	Y	N	N
0831	Peritoneal Opt or Home-Composite	830	N	Y	N	N
0832	Peritoneal Opt or Home-SupplieS	830	N	Y	N	N
0833	Peritoneal Opt or Home-Equipment	830	N	Y	N	N
0834	Peritoneal Opt or Home-Maint-100%	830	N	Y	N	N
0835	Peritoneal Opt or Home-Suppt Servi	830	N	Y	N	N
0839	Peritoneal Opt or Home-Other	830	N	Y	N	N
0840	CAPD Opt or Home-General	840	N	Y	N	N
0841	CAPD Opt or Home-Composite Rate	840	N	Y	N	N
0842	CAPD Opt or Home-Supplies	840	N	Y	N	N
0843	CAPD Opt or Home-Equipment	840	N	Y	N	N
0844	CAPD Opt or Home-Maint-100%	840	N	Y	N	N
0845	CAPD Opt or Home-Support Service	840	N	Y	N	N
0849	CAPD Opt or Home-Other	840	N	Y	N	N
0850	CCPD Opt or Home-General	850	N	Y	N	N
0851	CCPD Opt or Home-Composite Rate	850	N	Y	N	N
0852	CCPD Opt or Home-Home Supplies	850	N	Y	N	N
0853	CCPD Opt or Home-Equipment	850	N	Y	N	N
0854	CCPD Opt or Home-Maint-100%	850	N	Y	N	N
0855	CCPD Opt or Home-Support Services	850	N	Y	N	N
0859	CCPD Opt or Home-Other	850	N	Y	N	N
086X	Reserved for Dialysis-National Assign		N	N	N	N
087X	Reserved for Dialysis-National Assign		N	N	N	N
0880	Dialysis-Miscellaneous-General	880	Y	Y	Y	N
0881	Dialysis-Miscell-Ultrafiltration	880	Y	Y	Y	N
0882	Dialysis-Miscell-Home Dialy Aide Vis	880	N	N	N	N
0889	Dialysis-Miscellaneous-Other	880	Y	Y	Y	N
089X	Reserved for National Assignment		N	N	N	N
0900	Psychiatric/Psycholog Treat-General	900	Y	Y	N	N
0901	Psych/Psycho Treat-Electroshock	900	Y	Y	N	N
00902	Psych/Psycho Treat-Milieu Ther	900	Y	Y	N	N
0903	Psych/Psycho Treat-Play Therapy	900	Y	Y	N	N
0904	Psych/Psycho Treat-Activity Ther	900	Y	Y	N	N
0909	Psych/Psycho Treatment-Other	900	Y	Y	N	N
0910	Psych/Psycho Services-General	910	Y	Y	N	N
0911	Psych/Psycho Serv-Rehabilitation	910	N	Y	Y	Y
0912	Psych/Psycho Serv-Partial Hosp.	910	N	Y	N	N
0913	Psych/Psycho Serv-Part-Hosp-Intens	910	N	Y	N	N
0914	Psych/Psycho Serv-Individual Therapy	910	Y	Y	N	N
0915	Psych/Psycho Serv-Group Therapy	910	Y	Y	N	N
0916	Psych/Psycho Serv-Family Therapy	910	Y	Y	N	N
0917	Psych/Psycho Serv-Bio Feedback		N	N	N	N
0918	Psych/Psycho Serv-Testing	910	Y	Y	N	N
0919	Psych/Psycho Serv-Other	910	Y	Y	N	N
0920	Other Diagnostic Serv-General	920	Y	Y	Y	Y
0921	Other Diag. Serv-Peripheral-Vas-Lab	920	Y	Y	Y	Y
0922	Other Diag. Serv-EMG	920	Y	Y	Y	Y

0923	Other Diag. Serv-Pap Smear	920	Y	Y	Y	Y
0924	Other Diag. Serv-Allergy Test	920	Y	Y	Y	Y
0925	Other Diag. Serv-Pregnancy Test	920	Y	Y	Y	Y
0929	Other Diag. Serv-Other	920	Y	Y	Y	Y
0931	Medical Rehab Day - Half Day		N	N	N	N
0932	Medical Rehab Day - Full Day		N	N	N	N
0940	Other Therapeutic Serv-General	940	Y	Y	Y	Y
0941	Other Therap Serv-Recreational Therap		N	N	N	N
0942	Other Therap Serv-Education-Training		N	N	N	N
0943	Other Therap Serv-Cardiac Rehab	940	Y	N	Y	Y
0944	Other Therap Serv-Drug Rehab		N	N	N	N
0945	Other Therap Serv-Alcohol Rehab		N	N	N	N
0946	Other Therap Serv-Complex Medical Equipment-Routine	940	Y	N	Y	N
0947	Other Therap Serv-Complex Medical Equipment-Ancillary	940	Y	N	Y	N
0949	Other Therapeutic Services-Other	940	Y	Y	Y	Y
0950	Other Therap Services- Reserved		N	N	N	N
0951	Athletic Training		N	N	N	N
0952	Kinesiotherapy		N	N	N	N
0960	Professional Fees-General		Transplants only	N	N	N
0961	Prof Fees-Psychiatric		N	N	N	N
0962	Prof Fees-Opthalmology		N	N	N	N
0963	Prof Fees-Anesthesiology (MD)		N	N	N	N
0964	Prof Fees-Anesthetist (CRNA)		N	N	N	N
0969	Prof Fees-Other Prof. Fees		N	N	N	N
0970	Professional Fees-General-Delete		N	N	N	N
0971	Professional Fees-Laboratory		N	N	N	N
0972	Prof Fees-Radiology-Diagnostic		N	N	N	N
0973	Prof Fees-Radiology-Therapeutic		N	N	N	N
0974	Prof Fees-Radiology-Nuclear Med		N	N	N	N
0975	Prof Fees-Operating Room		N	N	N	N
0976	Prof Fees-Respiratory Therapy		N	N	N	N
0977	Prof Fees-Physical Therapy		N	N	N	N
0978	Prof Fees-Occupational Therapy		N	N	N	N
0979	Prof Fees-Speech Pathology		N	N	N	N
0981	Prof Fees-Emergency Room		N	N	N	N
0982	Prof Fees-Outpatient Services		N	N	N	N
0983	Prof Fees-Clinic		N	N	N	N
0984	Prof Fees-Medical Social Services		N	N	N	N
0985	Prof Fees-EKG		N	N	N	N
0986	Prof Fees-EEG		N	N	N	N
0987	Prof Fees-Hospital Visit		N	N	N	N
0988	Prof Fees-Consultation		N	N	N	N
0989	Prof Fees-Private Duty Nurse		N	N	N	N
0990	Patient Convenience Item-General		N	N	N	N
0991	Patient Conven Item-Caféteria/Guest		N	N	N	N
0992	Patient Conven Item-Pvt-Linen Service		N	N	N	N
0993	Patient Conven Item-Phone-Telegraph		N	N	N	N
0994	Patient Conven Item-TV-Radio		N	N	N	N
0995	Patient Conven Item-Non-Pat.Rm Rent		N	N	N	N

0996	Patient Conven Item-Late Discharge		N	N	N	N
0997	Patient Conven Item-Admission Kits	997	Y	N	Y	N
0998	Patient Conven Item-Barber-Beauty		N	N	N	N
0999	Patient Conven Item-Other		N	N	N	N
100X to	Reserved National Assignment					
209X	Reserved National Assignment					
2100	Alternative Therapy - General		N	N	N	N
2101	Alternative Therapy- Acupuncture		N	N	N	N
2102	Alternative Therapy- Accupressure		N	N	N	N
2103	Alternative Therapy- Massage		N	N	N	N
2104	Alternative Therapy- Reflexology		N	N	N	N
2105	Alternative Therapy-Biofeedback		N	N	N	N
2106	Alternative Therapy- Hynosis		N	N	N	N
2109	Alternative Therapy- Other		N	N	N	N
211X to	Reserved National Assignment					
300X	Reserved National Assignment					
3100	Adult Care - Not Used		N	N	N	N
3101	Adult Care -Medical & Social, Hourly		N	N	N	N
3102	Adult Care -Social, Hourly		N	N	N	N
3103	Adult Care -Medical & Social, Daily		N	N	N	N
3104	Adult Care - Social, Daily		N	N	N	N
3105	Adult Foster Care - Daily		N	N	N	N
3109	Adult Care - Other		N	N	N	N
311X thru	Reserved National Assignment					
999X	Reserved National Assignment					

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Provider's Medicaid ID Number	02 Last Name	03 First Name

04 Recipient ID Number	05 Patient's Account Number	06 Recipient's HIB Number (Medicare)

1

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

2

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

3

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

4

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident / Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ A ☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid By Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only

24 Remarks

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

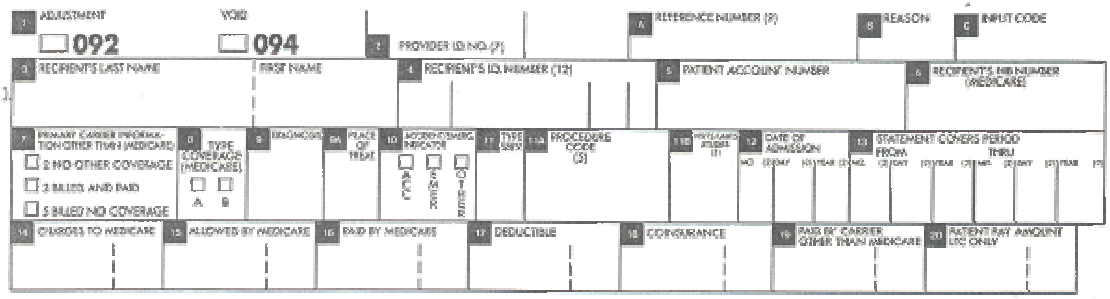
SIGNATURE DATE

DMAS - 30 R 6/03

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 6/96

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)* **M M D D C C Y Y** **Sequence Number (5 digits)**
Date of Service

***Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.**

Provider **Number:**	Provider Name:

Enrollee Identification Number:

Enrollee Last Name:	**First:**	**MI:**

☐ **Paper Attached** ☐ **Photo(s) Attached** ☐ **X-Ray(s) Attached**

☐ **Other (specify)**_____

COMMENTS:_____

_____

_____

_____

_____

_____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.state.va.us. Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

DMAS – 3

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.)
IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.

2. **Date of Service** – Enter the from date of service the attachment applies to.

3. **Sequence Number** –Enter the provider generated sequence number up to 5 digits only.

4. **Provider Number** – Enter the Medicaid Provider number.

5. **Provider Name** – Enter the name of the Provider.

6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.

7. **Enrollee Last Name -** Enter the last name of the Enrollee.

8. **First** – Enter the first name of the Enrollee.

9. **MI –** Enter the middle initial of the Enrollee.

10. **Type of Attachment –** Check the type of attachment or specify.

11. **Comment –** Enter comments if necessary.

12. **Authorized Signature –** Signature of the Provider or authorized Agent.

13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.state.va.us.